Don't cut out 'excisional' when considering debridement queries

This is one case when you can't 'cut it out.'

Recently a client contacted me regarding a surgeon who asked the coding department to stop querying him about excisional debridements. His comment was that all his debridements are excisional. He's a surgeon and he cuts. Bottom line. So please stop pestering him with the queries.

As most of us know, this clearly isn't enough to code a record and has been the reason for a significant number of concurrent and retrospective queries across country in many, many hospitals. The simplest solution, of course, is for the physician to use the words excisional debridement but as we all know, that simple solution doesn't always translate into simple reality.

What the client wanted to know was if they could make the assumption based upon his comment, that whenever he documented debridement, that he meant excisional and code to excisional. Again, I believe most of us would say that the documentation doesn't indicate excisional and needs further clarification. So how do we get the documentation and not irritate the physician?

In an attempt to help clear the water surrounding the word "excisional," many coding departments and documentation teams have made attempts to develop policies and procedures for clarifying this procedure. This became especially important with Recovery Audit Contractors (RACs) and other auditing agencies focusing on this specific procedure. Add to the mix the increasing number of elderly patients that are admitted with wounds that require care and then the number of non-excisional methods of treating these wounds. Clearly there is much to consider.

So what's the best approach? Of course education is important. Physicians must understand the importance of their documentation and how a single word (or lack thereof) impacts the severity of illness, risk of mortality, and reimbursement. Communication of coding guidelines and definitions becomes an important function of a documentation improvement team.

Whether through queries, newsletters, posters or presentations, it is important for a documentation team to recognize the need for an ongoing method to provide support and resources to healthcare providers regarding documentation. We need to help providers learn the vocabulary that best represents the diagnosis and care they provide to the patient. Making assumptions or creating policies that allow for ambiguous interpretation of documentation will only create other problems.

So, clearly this particular surgeon needs to understand that if he performed an excisional debridement then he needs to document "excisional debridement." Providing him with the information that defines an excisional versus non-excisional debridement is also important. Hopefully, once this information is shared, he will understand the need to include the appropriate words in his documentation. If not, that leaves the query process as an important part of the documentation process.

In answer to the question of whether it's okay to eliminate queries for excisional debridement if the physician documents just debridement, only the provider knows the depth to which he or she cut and therefore it becomes the responsibility of that healthcare provider to document accurately and appropriately. I know this answer doesn't necessarily make a

CDI specialist’s day, but look at the bright side; it’s another opportunity to have a conversation with a physician and spread the word of complete and consistent documentation!